**ARC 7795B**

# INSURANCE DIVISION[191]

**Notice of Intended Action**

**Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."***

**Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.**

Pursuant to the authority of Iowa Code sections 514D.3, 514D.4, 514D.9 and 507B.12, the Insurance Division hereby gives Notice of Intended Action to amend Chapter 15, "Unfair Trade Practices," and Chapter 37, "Medicare Supplement Insurance Minimum Standards," Iowa Administrative Code.

The rules in Chapter 37 provide for the standardization of coverage and simplification of terms and benefits of Medicare supplement policies. The proposed amendments bring the current rules into conformance with revisions to the model regulation issued by the National Association of Insurance Commissioners (NAIC). The proposed amendments also establish new Divison II of Chapter 37 which contains portions of the NAIC model regulation on advertising of Medicare supplement policies. The Division intends that the proposed amendments will go into effect August 19, 2009, and that Iowa insurance companies and producers will comply with the rules beginning August 19, 2009, for policies sold or issued on or after August 19, 2009.

Any interested person may make written suggestions or comments on these proposed amendments on or before June 10, 2009. Such written materials should be directed to Rosanne Mead, Assistant Insurance Commissioner, Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319; fax (515)281-3059.

There will be a public hearing on June 10, 2009, at 10 a.m. at the offices of the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa, at which time persons may present their views either orally or in writing. At the hearing, persons will be asked to give their names and addresses for the record and to confine their remarks to the subject of the amendments.

Any persons who intend to attend the public hearing and have special requirements, such as those relating to hearing or mobility impairments, should contact the Division and advise of specific needs.

These amendments are intended to implement Iowa Code chapters 507B and 514D.

The following amendments are proposed.

ITEM 1. Adopt the following **new** subrule 15.3(14):

**15.3(14)** *Compliance with Medicare supplement advertising rules.* Insurers and producers shall comply with the Medicare supplement advertising rules set forth in 191—Chapter 37, Division II.

ITEM 2. Amend **191—Chapter 37**, title, as follows:

MEDICARE SUPPLEMENT INSURANCE ~~MINIMUM STANDARDS~~

ITEM 3. Adopt the following **new** division heading immediately preceding rule **191—37.1(514D)**:

DIVISION I
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

ITEM 4. Rescind subrule **37.2(3)**.

ITEM 5. Amend rule **191—37.3(514D)**, definition of "Medicare Advantage," as follows:

*"Medicare Advantage plan"* means a plan of coverage for health benefits under Medicare Part C (as defined in 42 U.S.C. 1395w-28(b)(1)), and includes:

1. to 3. No change.

ITEM 6. Adopt the following **new** definitions in rule **191—37.3(514D)**:

*"1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan"* or *"1990 plan"* means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after June 1, 2010, which are not replaced by the issuer at the request of the insured.

*"2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan"* or *"2010 plan"* means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

*"Prestandardized Medicare supplement benefit plan"* or *"prestandardized plan"* means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992.

ITEM 7. Amend subrule 37.5(1) as follows:

**37.5(1)** Except for permitted preexisting condition clauses as described in 37.6(1)*"a,"* ~~and~~ 37.7(1)*"a,"* and 37.8(1)*"a,"* no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

ITEM 8. Amend rule 191—37.6(514D), catchwords, as follows:

**191—37.6(514D) Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992.**

ITEM 9. Amend paragraph **37.6(1)"c"** as follows:

*c.* A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible ~~amount and copayment percentage factors~~, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

ITEM 10. Amend rule 191—37.7(514D), introductory paragraph, as follows:

**191—37.7(514D) Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued ~~or delivered~~ for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

ITEM 11. Amend paragraph **37.7(1)"c"** as follows:

*c.* A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible ~~amount and copayment percentage factors~~, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

ITEM 12. Adopt the following **new** paragraph **37.7(1)"h"**:

*h.* If an issuer makes a written offer to the Medicare supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period the insured's 1990 standardized plan (as described in rule 191—37.9(514D)) for a 2010 standardized plan (as described in rule 191—37.10(514D)), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the commissioner if the insured exchanges a 1990 standardized policy or certificate for an issue-age-rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's 1990 standardized policy or certificate to be exchanged is priced on an issue-age rate schedule at the time of such offer, the rate charged to the insured for the new 2010 exchanged standardized policy or certificate shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue-age rate basis, for the benefit of the insured.

The method proposed to be used by an issuer must be filed with the commissioner pursuant to rule 191—37.15(514D).

(2) The rating class of the new 2010 standardized policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(3) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new 2010 standardized policy or certificate for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged 1990 standardized policy or certificate.

(4) The new 2010 standardized policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

ITEM 13. Renumber rule **191—37.8(514D)** as **191—37.9(514D)**.

ITEM 14. Adopt the following **new** rule 191—37.8(514D):

**191—37.8(514D) Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. Insurers may begin submitting policies and certificates to the division for approval on or after January 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of rule 191—37.7(514D).

**37.8(1)** *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

*a.* A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

*b.* A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

*c.* A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

*d.* No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

*e.* Each Medicare supplement policy shall be guaranteed renewable.

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 37.8(1)*"e"*(5), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

1. Provides for continuation of the benefits contained in the group policy; or
2. Provides for benefits that otherwise meet the requirements of paragraph 37.8(1)*"e."*

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in subparagraph 37.8(1)*"e"*(3); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the group policy that is being replaced on that policy's date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

*f.* Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

*g.* Suspension of benefits.

(1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificate holder if the policyholder or certificate holder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of the loss.

(4) Reinstitution of coverage as described in subparagraphs 37.8(1)*"g"*(2) and (3):

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

**37.8(2)** *Standards for basic (core) benefits common to Medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M and N.* Every issuer of Medicare supplement insurance benefit plans shall make available to each prospective insured a policy or certificate including only the following basic (core) package of benefits. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. The basic core package must provide:

*a.* Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

*b.* Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

*c.* Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

*d.* Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

*e.* Coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible; and

*f.* Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

**37.8(3)** *Standards for additional benefits.* The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided by rule 191—37.10(514D):

*a.* Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

*b.* Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

*c.* Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredeth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

*d.* Medicare Part B Deductible: Coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

*e.* One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge; and

*f.* Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

ITEM 15. Amend renumbered rule 191—37.9(514D), catchwords, as follows:

**191—37.9(514D) Standard Medicare supplement benefit plans <u>for 1990 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage prior to June 1, 2010</u>.**

ITEM 16. Renumber rule **191—37.9(514D)** as **191—37.11(514D)**.

ITEM 17. Renumber rule **191—37.10(514D)** as **191—37.12(514D)**.

ITEM 18. Adopt the following **<u>new</u>** rule 191—37.10(514D):

**191—37.10(514D) Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after June 1, 2010.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this

state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of rules 191—37.6(514D) and 191—37.9(514D).

**37.10(1)** Issuer to make form available.

*a.* An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subrule 37.8(2).

*b.* If an issuer makes available any of the additional benefits described in subrule 37.8(3) or offers standardized benefit Plans K or L (as described in paragraphs 37.10(5)*"h"* and *"i"*), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph 37.10(1)*"a,"* a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph 37.10(5)*"c"*) or standardized benefit Plan F (as described in paragraph 37.10(5)*"e"*).

**37.10(2)** No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.10(6) and rule 191—37.11(514D).

**37.10(3)** Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in rule 191—37.10(514D) and conform to the definitions in rule 191—37.3(514D). Each benefit plan shall be structured in accordance with the format provided in subrules 37.8(2) and 37.8(3), or, in the case of Plan K or L, each benefit plan shall be structured in accordance with the format provided in paragraphs 37.10(5)*"h"* and *"i."* Each plan shall list the benefits in the order shown. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

**37.10(4)** In addition to the benefit plan designations required in subrule 37.10(3), an issuer may use other designations to the extent permitted by law.

**37.10(5)** Makeup of 2010 standardized benefit plans.

*a.* Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subrule 37.8(2).

*b.* Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible as defined in paragraph 37.8(3)*"a."*

*c.* Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d,"* and *"f,"* respectively.

*d.* Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c,"* and *"f,"* respectively.

*e.* Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d," "e,"* and *"f,"* respectively.

*f.* Standardized Medicare supplement Plan F with high deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph 37.10(5)*"f"*(2).

(1) The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d," "e,"* and *"f,"* respectively.

(2) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

*g.* Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "e,"* and *"f,"* respectively.

*h.* Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) Part A hospital coinsurance from the sixty-first through ninetieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(2) Part A hospital coinsurance from the ninety-first through one hundred fiftieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(3) Part A hospitalization after 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Medicare Part A deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(5) Skilled nursing facility care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredeth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(6) Hospice care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(7) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(8) Part B cost sharing: Except for coverage provided in subparagraph 37.10(5)*"h"*(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificate holder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(9) Part B preventive services: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder or certificate holder pays the Part B deductible; and

(10) Cost sharing after out-of-pocket limits: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

*i.* Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) The benefits described in subparagraphs 37.10(5)*"h"*(1), (2), (3) and (9);

(2) The benefits described in subparagraphs 37.10(5)*"h"*(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent; and

(3) The benefit described in subparagraph 37.10(5)*"h"*(10), but substituting $2000 for $4000.

*j.* Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 50 percent of the Medicare Part A deductible, 100 percent of skilled nursing facility care, and 100 percent of medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"b," "c,"* and *"f,"* respectively.

*k.* Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c,"* and *"f,"* respectively, with copayments in the following amounts:

(1) The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(2) The lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

**37.10(6)** New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. The commissioner shall use any guidelines issued by the National Association of Insurance Commissioners in determining whether to approve new or innovative benefits.

ITEM 19. Renumber rule **191—37.11(514D)** as **191—37.13(514D)**.

ITEM 20. Renumber rule **191—37.12(514D)** as **191—37.14(514D)**.

ITEM 21. Renumber rule **191—37.13(514D)** as **191—37.15(514D)**.

ITEM 22. Renumber rule **191—37.14(514D)** as **191—37.16(514D)**.

ITEM 23. Rescind rule **191—37.17(514D)**.

ITEM 24. Renumber rule **191—37.15(514D)** as **191—37.17(514D)**.

ITEM 25. Amend renumbered paragraph **37.17(4)"c"** as follows:

*c.* The outline of coverage provided to applicants pursuant to this subrule consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans ~~"A" to "L"~~ shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

ITEM 26. Rescind renumbered paragraph **37.17(4)"d"** and adopt the following **new** paragraph in lieu thereof:

*d.* The following items shall be included in the outline of coverage in the order prescribed below.

**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010.**
This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

**Basic Benefits:**

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

| A | B | C | D | F | F* | G | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|
| Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance* | | Basic, including 100% Part B co-insurance | Hospitalization and preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventive care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance, except up to $20 copayment for office visit, and up to $50 copayment for ER |
| | | Skilled Nursing Facility Co-insurance | Skilled Nursing Facility Co-insurance | Skilled Nursing Facility Co-insurance | | Skilled Nursing Facility Co-insurance | 50% Skilled Nursing Facility Co-insurance | 75% Skilled Nursing Facility Co-insurance | Skilled Nursing Facility Co-insurance | Skilled Nursing Facility Co-insurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | | Part A Deductible | 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | Part A Deductible |
| | | Part B Deductible | | Part B Deductible | | | | | | |
| | | | | Part B Excess (100%) | | Part B Excess (100%) | | | | |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | | Foreign Travel Emergency | | | Foreign Travel Emergency | Foreign Travel Emergency |
| | | | | | | | Out-of-pocket limit $[4140]; paid at 100% after limit reached | Out-of-pocket limit $[2070]; paid at 100% after limit reached | | |

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[1860] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [The last sentence of this paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[for agents: ]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response: ]

[Insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services, Medicare payments, plan payments and insured payments, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this subrule. An issuer may use additional benefit plan descriptions on these charts pursuant to subrule 37.10(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $0 | $[992] (Part A deductible) |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | $0 | Up to $[124] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES**—<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[992] (Part A deductible) | $0 |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | $0 | Up to $[124] a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES**—<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[992] (Part A deductible) | $0 |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[124] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES**—<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $[131] (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts* | $0 | $[131] (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $[131] (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL—NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[992] (Part A deductible) | $0 |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[124] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES**—<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL—NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[992] (Part A deductible) | $0 |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[124] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES**— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $[131] (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges** (Above Medicare-Approved Amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts* | $0 | $[131] (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**— TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $[131] (Part B deductible) | $0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL—NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION***<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[992] (Part A deductible) | $0 |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE***<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[124] a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES**—<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | 100% | 0% |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL—NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

PLAN K

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[496] (50% of Part A deductible) | $[496] (50% of Part A deductible)♦ |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[62] a day | Up to $[62] a day ♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | 50% of copayment/ coinsurance | 50% of Medicare copayment/ coinsurance♦ |

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES**— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts**** | $0 | $0 | $[131] (Part B deductible)**** ♦ |
| Preventive Benefits for Medicare-Covered Services | Generally 75% or more of Medicare-Approved Amounts | Remainder of Medicare-Approved Amounts | All costs above Medicare-Approved Amounts |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 10% | Generally 10% ♦ |
| **Part B Excess Charges** (Above Medicare-Approved Amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of [$4140])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 50% | 50%♦ |
| Next $[131] of Medicare-Approved Amounts**** | $0 | $0 | $[131] (Part B deductible)**** ♦ |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 10% | Generally 10% ♦ |
| **CLINICAL LABORATORY SERVICES**— TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4140] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment First $[131] of Medicare-Approved Amounts***** | $0 | $0 | $[131] (Part B deductible) ♦ |
| Remainder of Medicare-Approved Amounts | 80% | 10% | 10%♦ |

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**<br>Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[744] (75% of Part A deductible) | $[248] (25% of Part A deductible)♦ |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE****<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[93] a day | Up to $[31] a day♦ |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | 75% of copayment/ coinsurance | 25% of copayment/ coinsurance♦ |

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES**— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts**** | $0 | $0 | $[131] (Part B deductible)**** ♦ |
| Preventive Benefits for Medicare-Covered Services | Generally 75% or more of Medicare-Approved Amounts | Remainder of Medicare-Approved Amounts | All costs above Medicare-Approved Amounts |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 15% | Generally 5% ♦ |
| **Part B Excess Charges** (Above Medicare-Approved Amounts) | $0 | $0 | All costs (and they do not count toward annual out-of-pocket limit of $[2070])* |
| **BLOOD** | | | |
| First 3 pints | $0 | 75% | 25%♦ |
| Next $[131] of Medicare-Approved Amounts**** | $0 | $0 | $[131] (Part B deductible) ♦ |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 15% | Generally 5%♦ |
| **CLINICAL LABORATORY SERVICES**— TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2070] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment First $[131] of Medicare-Approved Amounts***** | $0 | $0 | $[131] (Part B deductible) ♦ |
| Remainder of Medicare-Approved Amounts | 80% | 15% | 5%♦ |

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION**** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[496] (50% of Part A deductible) | $[496] (50% of Part A deductible) |
| 61st through 90th day | All but $[248] a day | $[496] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0*** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE**** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[124] a day | $0** |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES**—<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20% | 0% |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts**** | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment<br>First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) ♦ |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL—NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $[992] | $[992] (Part A deductible) | $0 |
| 61st through 90th day | All but $[248] a day | $[248] a day | $0 |
| 91st day and after: | | | |
| —While using 60 lifetime reserve days | All but $[496] a day | $[496] a day | $0 |
| —Once lifetime reserve days are used: | | | |
| —Additional 365 days | $0 | 100% of Medicare eligible expenses | $0** |
| —Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $[124] a day | Up to $[124] a day | $0** |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **MEDICAL EXPENSES**—<br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | Generally 80% | Balance, other than up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| **Part B Excess Charges**<br>(Above Medicare-Approved Amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $[131] of Medicare-Approved Amounts** | $0 | $0 | $[131] (Part B deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES**—<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY* |
|---|---|---|---|
| **HOME HEALTH CARE**<br>MEDICARE-APPROVED SERVICES | | | |
| —Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| —Durable medical equipment<br>First $[131] of Medicare-Approved Amounts* | $0 | $0 | $[131] (Part B deductible) ♦ |
| Remainder of Medicare-Approved Amounts | 80% | 20% | $0 |

OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL—NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

ITEM 27. Renumber rule **191—37.16(514D)** as **191—37.18(514D)**.

ITEM 28. Renumber rules **191—37.18(514D)** to **191—37.21(514D)** as **191—37.19(514D)** to **191—37.22(514D)**.

ITEM 29. Renumber rule **191—37.22(514D)** as **191—37.26(514D)**.

ITEM 30. Renumber rule **191—37.23(514D)** as **191—37.24(514D)**.

ITEM 31. Adopt the following **new** rule 191—37.23(514D):

**191—37.23(514D) Prohibition against use of genetic information and requests for genetic testing.** This rule applies to all policies with policy years beginning on or after May 21, 2009.

**37.23(1)** For the purposes of this rule only, the following definitions shall apply:

*"Family member"* means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

*"Genetic information"* means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. "Genetic information" includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by such pregnant woman or, with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

*"Genetic services"* means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

*"Genetic test"* means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean:

1. An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
2. An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

*"Issuer of a Medicare supplement policy or certificate"* means the same as "issuer" as defined in rule 191—37.3(514D) and includes third-party administrator, or other person acting for or on behalf of such issuer.

*"Underwriting purposes"* means:

1. Rules for or determination of eligibility (including enrollment and continued eligibility) for benefits under the policy;
2. The computation of premium or contribution amounts under the policy;
3. The application of any preexisting condition exclusion under the policy; and
4. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**37.23(2)** An issuer of a Medicare supplement policy or certificate:

*a.* Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) of an individual on the basis of the genetic information with respect to such individual; and

*b.* Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

**37.23(3)** Nothing in subrule 37.23(2) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

*a.* Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

*b.* Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of another individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

**37.23(4)** An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

**37.23(5)** Subrule 37.23(4) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subrule 37.23(2).

**37.23(6)** For purposes of carrying out subrule 37.23(5), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

**37.23(7)** Notwithstanding subrule 37.23(4), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

*a.* The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

*b.* The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

*c.* No genetic information collected or acquired under this subrule shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

*d.* The issuer notifies the Secretary of the U.S. Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subrule, including a description of the activities conducted.

*e.* The issuer complies with such other conditions as the Secretary of the U.S. Department of Health and Human Services may by regulation require for activities conducted under this subrule.

**37.23(8)** An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

**37.23(9)** An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

**37.23(10)** If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subrule 37.23(9) if such request, requirement, or purchase is not in violation of subrule 37.23(8).

ITEM 32. Renumber rule **191—37.24(514D)** as **191—37.25(514D)**.

ITEM 33. Reserve rules **191—37.27** to **191—37.49**.

ITEM 34. Adopt the following **new** division heading in **191—Chapter 37**:

DIVISION II
MEDICARE SUPPLEMENT ADVERTISING

ITEM 35. Adopt the following **new** rules 191—37.50(507B,514D) to 191—37.59(507B,514D):

**191—37.50(507B,514D) Purpose.** The purpose of the rules in this division is to provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement

insurance and to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising of Medicare supplement insurance in a manner which prevents unfair, deceptive and misleading advertising and which is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance producers and companies.

**191—37.51(507B,514D) Applicability.**

**37.51(1)** "Insurer," for the purpose of these rules, shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity which is defined as an "issuer" in rule 191—37.3(514D) and is engaged in the advertisement of itself, or Medicare supplement insurance.

These rules shall apply to any "advertisement" of Medicare supplement insurance, as that term is defined in rule 191—37.52(507B,514D), unless otherwise specified in Division II of this chapter, that the insurer or producer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer or producer, as those terms are defined in rule 191—15.2(507B).

**37.51(2)** Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

**37.51(3)** The requirements of Iowa Code chapter 507B and 191—Chapter 15 also shall apply to insurers and producers to which 191—Chapter 37, Division II, applies, unless specifically exempted therein.

**191—37.52(507B,514D) Definitions.** In addition to the definitions in Iowa Code section 507B.2 and rule 191—15.2(507B), the following definitions shall apply to 191—Chapter 37, Division II. When there is a definition for a term in this rule and also in Iowa Code section 507B.2 or rule 191—15.2(507B), the definition in this rule shall take precedence.

*"Advertisement"* includes:

1. The definition of "advertisement" in rule 191—15.2(507B).
2. Advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.
3. The definition of "advertisement" does not include:

- Items excluded in the definition of "advertisement" in rule 191—15.2(507B).
- Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract.
- Court-approved material ordered by a court to be disseminated to policyholders.

*"Certificate"* means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

*"Institutional advertisement"* means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of Medicare supplement insurance, or the promotion of the insurer as a seller of Medicare supplement insurance.

*"Lead-generating device"* means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

*"Limitation"* means any provision other than an exception or a reduction that restricts coverage under the policy.

*"Medicare"* means "The Health Insurance for the Aged Act, Title XVIII of The Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I, of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America, and also known as the "Health

Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

*"Medicare supplement insurance"* means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

*"Person"* means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

*"Reduction"* means any provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable had the reduction not been used.

**191—37.53(507B,514D) Form and content of advertisements.** An insurer must clearly identify its Medicare supplement insurance policy as an insurance policy. A policy trade name must be followed by the words "Insurance Policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

**191—37.54(507B,514D) Testimonials or endorsements by third parties.** In addition to complying with 191—subrule 15.3(7), when a testimonial refers to benefits received under a Medicare supplement insurance policy, the insurer shall retain the specific claim data, including claim number, date of loss, and other pertinent information, for a period of four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

**191—37.55(507B,514D) Use of statistics; jurisdictional licensing; status of insurer.** Advertisements shall be in compliance with 191—subrule 15.3(5) and with the following:

**37.55(1)** An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate and, where statistics are given which are applicable to a different policy, the advertisement shall state clearly that the data do not relate to the policy being advertised.

**37.55(2)** An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

**37.55(3)** An advertisement shall not create the impression directly or indirectly that the insurer, the insurer's financial condition or status, the insurer's payment of its claims, or the merits, desirability or advisability of the insurer's policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this state or of the United States government.

**37.55(4)** An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of this state or of the United States government. "Approval" of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, its advertising or its financial condition.

**191—37.56(507B,514D) Identity of insurer.** Advertisements shall be in compliance with 191—subrule 15.3(9) and with the following:

**37.56(1)** Advertisements, stationery or envelopes that employ words, letters, initials, symbols or other devices are not permitted if they are so similar to those used by governmental agencies or other insurers that they may lead the public to believe:

*a.* The advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;

*b.* The advertiser is the same as, is connected with or is endorsed by the governmental agencies or the other insurers.

**37.56(2)** No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

**37.56(3)** No advertisement in the form of envelopes or stationery of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

**37.56(4)** No advertisement may incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating the plan or policy from Medicare. Such an advertisement, however, shall not use the phrase "_____ Medicare Department of the _____ Insurance Company," or language of similar import.

**37.56(5)** No advertisement shall be used that fails to include a disclaimer to the effect of "Not connected with or endorsed by the U.S. government or the federal Medicare program."

**37.56(6)** No advertisement may imply that the reader may lose a right, privilege or benefit under federal, state or local law if the reader fails to respond to the advertisement.

**37.56(7)** No insurer may use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

**37.56(8)** All advertisements used by producers or solicitors of an insurer shall have prior written approval of the insurer before the advertisements may be used.

**37.56(9)** A producer who makes contact with a consumer as a result of acquiring that consumer's name from a lead-generating device shall disclose that fact in the initial contact with the consumer.

**191—37.57(507B,514D) Introductory, initial or special offers.**

**37.57(1)** Enrollment periods.

*a.* An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such representation is true. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

*b.* An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not fewer than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This rule applies to all advertising media, e.g., mail, newspapers, electronic mail, Web sites, radio, television, magazines and periodicals, used by any one insurer. This rule is not applicable to solicitations of employees or members of a particular group or association that otherwise would be eligible for group, blanket or franchise insurance. The phrase "any one insurer" in this paragraph includes all the affiliated companies of a group of insurance companies under common management or control. The phrase "a particular insurance product" in this paragraph means an insurance policy that provides benefits substantially different from those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product's being offered as a different product eligible for concurrent or overlapping enrollment periods.

*c.* This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless either is true.

**37.57(2)** An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium shall be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term "juxtaposition" means side by side or immediately above or below.

**37.57(3)** Special awards, such as a "safe driver's award," shall not be used in connection with advertisements of Medicare supplement insurance.

**37.57(4)** An invitation to inquire, which means an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance that is limited to a brief description of coverage, shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reductions of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance producer or the company [whichever is applicable]."

**191—37.58(507B,514D) Enforcement procedures—certificate of compliance.** Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of these rules must file with the insurance division, with the insurer's annual statement, a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of the authorized officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied with or were made to comply in all respects with the provisions of these rules and the laws of this state as implemented and interpreted by these rules.

**191—37.59(507B,514D) Filing for prior review.** The commissioner may, at the commissioner's discretion, require the filing with the insurance division, for review prior to use, of any Medicare supplement insurance advertising material.

ITEM 36. Amend **191—Chapter 37**, implementation sentence, as follows:

These rules are intended to implement Iowa Code ~~chapter~~ chapters 507B and 514D.